

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01340

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grindstone</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grindstone Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. STREET ADDRESS <u>Columbia road 1 mile east of Grindstone</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walmer</u> Middle <u>Kenneth</u> Last <u>Ballard</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 23 57</u>	9. AGE (In years last birthday) yrs. <u>4</u> Months <u>1</u> Days <u>17</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Walmer Alonzo Ames</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ballard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Sarah Ballard</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho Pneumonia</u> DUE TO (b) <u>Cold + infection</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Due to</u> DUE TO (c) <u>Due to</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lapsed resistance - weight loss</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N.E. Sartorius</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grindstone</u>		22d. LOCATION (City, town, or county)		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Smith</u>				ADDRESS <u>Grindstone, MD</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
				DATE <u>11/11/58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

and fill in

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BUREAU V. E.

JAN 14 1958

RECEIVED

1349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City				c. LENGTH OF STAY IN 1b 52 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3				d. STREET ADDRESS 1 RFD #3			
3. NAME OF DECEASED (Type or print) First PAUL Middle T. Last BARNES				4. DATE OF DEATH Month January Day 16 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Barnes				14. MOTHER'S MAIDEN NAME Virginia Lankford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Robert Scott, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Chronic Hypertension							INTERVAL BETWEEN ONSET AND DEATH years years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 16, 1958 , to Jan 16, 1958 , that I last saw the deceased alive on Jan 16, 1958 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE C. E. Critcher M.D.				PHYSICIAN'S NAME (Type) C. E. CRITCHER, M.D. New Church, Virginia			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-58		22c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		22d. LOCATION (City, town, or county) (State) Rural-Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Watson ADDRESS Pocomoke, Md.				24a. REC'D BY REGISTRAR DATE JAN 21 '58		24b. REGISTRAR'S SIGNATURE Quint...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01342

1350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>S.</u> Last <u>Bowen</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29 - 1877</u>
9. AGE (In years Day birthday) <u>80</u> <u>9</u> <u>25</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Charles H Bowen</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Henman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mattie W Bowen, Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of tongue</u> <u>141.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Dec 6</u> , 19 <u>55</u> , to <u>Jan 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>58</u> , and that death occurred at <u>8 A.</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Paul Bowen</u> M.D.		DATE SIGNED <u>Snow Hill, md</u>	
PHYSICIAN'S NAME (Type) <u>S</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 24/58</u>	
22b. NAME OF CEMETERY OR CREMATORY <u>Bethesda Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne Dennis</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

JAN 28 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01343

1351

Item 7 FilmG225 2-7-58 et.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY WOR	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ocean City		c. LENGTH OF STAY IN 1b 7 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) West Ocean City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas — Cherry		4. DATE OF DEATH JAN 25 1958	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Noah Cherry		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-5703	
17. INFORMANT Mrs Jenny Adkins Cherry		Address Ocean City Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410x DEFERRED / PENDING / Autopsy DUE TO Acute dilatation of heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mitral Insufficiency DUE TO Myocardial Hypertrophy (c) Myocardial Hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 5 minutes 2 yrs. 2 yrs.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Francis J. Townsend Jr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Francis J. Townsend Jr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED JAN 28, 58.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/1958	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Berlin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md		ADDRESS	
24a. REC'D BY REGISTRAR FEB 4 '58		24b. REGISTRAR'S SIGNATURE Aw. Smith	

WYOMING STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FEB 4 1958
BUREAU V. B.

CERTIFICATE OF DEATH

Reg. Dist. No.

01344

1352

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>78 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 JEFFERSON</u>	
3. NAME OF DECEASED (Type or print) First <u>HORACE</u> Middle <u>O.</u> Last <u>CROPPER</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 16, 1879</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE OP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES P. CROPPER</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE ZUILLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES SPAN. AMER.</u>		16. SOCIAL SECURITY NO. <u>214-32-727</u>	
17. INFORMANT <u>MR. JACK FARLOW</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy sec. Arteriosclerosis Sen</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Diabetes Mellitus, Degenerative</u> DUE TO (c) <u>Myocarditis - Degenerative</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>15 yrs</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio Sclerosis, severe; Lic. Diabetes Mellitus</u>			
20a. CONTRIBUTING WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 8</u> , 19 <u>58</u> , to <u>Jan 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>58</u> , and that death occurred at <u>12:15 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harman G. Robbins</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Harman A. Robbins M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>Jan 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100

1. NAME OF DECEASED JAMES M. SMITH		2. SEX Male		3. AGE 65	
4. OCCUPATION Carpenter		5. PLACE OF BIRTH Maryland		6. DATE OF BIRTH Jan 15, 1893	
7. MARITAL STATUS Married		8. PLACE OF DEATH Home		9. DATE OF DEATH Jan 15, 1958	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. M. Smith	
13. SIGNATURE OF REGISTRAR J. M. Smith		14. SIGNATURE OF WITNESS J. M. Smith		15. SIGNATURE OF DECEASED J. M. Smith	

RECEIVED
JAN 15 1958
BUREAU V. 8

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS PHILADELPHIA AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IRMA Middle S. Last CROPPER		4. DATE OF DEATH Month JAN. Day 30 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7, 1906
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) BERLIN MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK TYRE		14. MOTHER'S MAIDEN NAME ELIZABETH TIMMONS.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT MRS. EVELYN Aikin		Address OCEAN CITY MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592X DUE TO Chronic nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 weeks (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 56 to Jan 30, 1958 , that I last saw the deceased alive on Jan 30, 1958 , and that death occurred at 3:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ocean City Md. DATE SIGNED FEB 1, 58			
ACTUAL SIGNATURE F. J. Townsend, Jr.		PHYSICIAN'S NAME (Type) F. J. Townsend, Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/2/58	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN	22d. LOCATION (City, town, or county) (State) BERLIN MD.
23. FUNERAL DIRECTOR'S SIGNATURE F. J. Townsend, Jr.		ADDRESS Ocean City Md.	
24a. REC'D BY REGISTRAR DATE FEB 3 1958		24b. REGISTRAR'S SIGNATURE Overhach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

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DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

FEB 3 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1354

CERTIFICATE OF DEATH

Reg. Dist. No.

01346

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Berlin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Berlin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) Robert First Cutler Middle Last		4. DATE OF DEATH Month 1 Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-5895	
17. INFORMANT Mrs. Pauline Purnell, Berlin Md, Route #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertensive Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 1/2 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/29, 1957 , to 12/17, 1957 , that I last saw the deceased alive on 12/17, 1957 , and that death occurred at 2 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.		ADDRESS (Street, city or town, state) Berlin Md	
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.		DATE SIGNED 1/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-8-1958	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Berlin, Md
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.		24a. REC'D BY REGISTRAR DATE N 1 3 '58	
24b. REGISTRAR'S SIGNATURE Alb. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Baltimore, Maryland		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. DATE OF DEATH Jan 13, 1968	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF CORONER	
17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF CLERK		19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	

BUREAU V. 5

JAN 13 1968

RECEIVED

1355

CERTIFICATE OF DEATH

Reg. Dist. No.

01347

1. PLACE OF DEATH a. COUNTY <i>Worcester</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <i>md</i> b. COUNTY <i>Worcester</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Della</i> Middle <i>S.</i> Last <i>Evans</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>11</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 2 - 1879</i>	
9. AGE in years <i>78 5/9</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>10</i> Hours <i>15</i> Min.		11. BIRTHPLACE (State of foreign country) <i>Snow Hill, md</i>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13. FATHER'S NAME <i>John Hals</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Frank Evans</i> Address <i>Snow Hill, md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>10 yrs</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 Hrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>p. m.</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , 19____, to <i>1-11-58</i> , 19____, that I last saw the deceased alive on <i>1-11-58</i> , 19____, and that death occurred at <i>1:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert C. Lamar</i> M.D.				ADDRESS (Street, city or town, state) <i>104 B B St Snow Hill, Md</i>		DATE SIGNED <i>1/13/58</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT C. LAMAR</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Jan. 14/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Catholic Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill, md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton</i> ADDRESS <i>Snow Hill, md</i>				24a. REC'D BY REGISTRAR <i>Alb. Leach</i>		24b. REGISTRAR'S SIGNATURE	
				DATE <i>JAN 15 '58</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

1953

RECEIVED
JAN 15 1958
BUREAU V. 1

1356 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomac	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RED #2		d. STREET ADDRESS Leemont 83X-3	
3. NAME OF DECEASED (Type or print) First BERTHA Middle G. Last GARRETT		4. DATE OF DEATH Month January Day 31 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1891 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Germroth		14. MOTHER'S MAIDEN NAME Ella Bishop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 65-05-8904	
17. INFORMANT Rev. C.C. Garrett, Leemont, Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic Nephritis. DUE TO (c) Chronic Glomerular Nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural Effusion of Undetermined Origin			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 27, 1958 to Jan. 31, 1958 , that I last saw the deceased alive on Jan. 31, 1958 , and that death occurred at 700p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 302 Market Street DATE SIGNED 2-1-58			
ACTUAL SIGNATURE Charles W. Trader M.D.		ADDRESS 302 Market Street DATE SIGNED 2-1-58	
PHYSICIAN'S NAME (Type) Charles W. Trader M.D.		ADDRESS Pocomoke City, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-5-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	22d. LOCATION (City, town, or county) (State) Drexel Hill, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Henry L. Watson		ADDRESS Pocomoke, Md.	
24a. REC'D BY REGISTRAR Feb 5 1958		24b. REGISTRAR'S SIGNATURE DeWitt	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 3 1958

RECEIVED

1357 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle F. Last GOOTEE				4. DATE OF DEATH Month January Day 30 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1898		9. AGE (In years lost birthday) yrs. 59	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Gootee				14. MOTHER'S MAIDEN NAME Bessie Lee Timmons			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 217-36-1014		17. INFORMANT Address Mrs Milton A. Payne, Pocomoke, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Larynx 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 1, 1957 to Jan. 30, 1958 , that I last saw the deceased alive on Jan. 29, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles W. Trader ADDRESS (Street, city or town, state) 302 Market St., Pocomoke City, Md. DATE SIGNED 1-31-58							
PHYSICIAN'S NAME (Type) Charles W. Trader,							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-58		22c. NAME OF CEMETERY OR CREMATOR Remson Methodist		22d. LOCATION (City, town, or county) (State) Rural Pocomoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sherry Stinson				24a. REC'D BY REGISTRAR Pocomoke, Md.		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1953 FEB 3

RECEIVED

1358

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Film 0221 1-27-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution/Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree Rural</u>		c. LENGTH OF STAY IN 1b <u>22 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree Rural</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E.</u> Last <u>Hearne</u>		d. STREET ADDRESS <u>Box 100</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 30 1918</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>16</u> Year <u>1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Worcester County, Md</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Girdletree, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Evelyn</u>		14. MOTHER'S MAIDEN NAME <u>Lola Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>220-62-1678</u>	
17. INFORMANT <u>John Hearne (Husband)</u>		Address <u>Girdletree Rd Route 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>982x</u> DUE TO <u>Hemorrhages</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Star wounds of chest + chest throat</u> DUE TO (c) <u>Star wounds of chest + chest throat</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>"attempted Rape" (?)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I and Part II of item 18.) <u>3 negro men attacked her while she was alone on her back in the store, their hands on her chest and throat</u>	
20c. TIME OF INJURY Month, Day, Year <u>Jan 16 1958</u> Hour <u>10</u> a.m. <u>1</u> p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Husband's store</u>	
20f. (City or town) <u>Box 100, Worcester Md</u>		20g. (County) <u>Worcester</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Buried Jan 19/58</u>		22b. DATE THEREOF <u>Jan 19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christian Unity</u>		22d. LOCATION (City, town, or county) <u>Snow Hill</u>	
22e. ADDRESS <u>Snow Hill, Md</u>		22f. (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Huns</u>		24a. REC'D BY REGISTRAR <u>W.D. Seach</u>	
24b. REGISTRAR'S SIGNATURE <u>W.D. Seach</u>		24c. DATE <u>JAN 20 '58</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM-3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BAY STATE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for narrative notes.

BUREAU V. 2

JAN 20 1968

Handwritten notations and stamps at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1359

CERTIFICATE OF DEATH

Reg. Dist. No.

01351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Route #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Route #2</u>	
c. LENGTH OF STAY IN 1b <u>39 yrs</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J.</u> Last <u>Mason</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 - 1869</u>
9. AGE (In years only birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Accomac, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Derry Mason</u>		14. MOTHER'S MAIDEN NAME <u>Clara Pullman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, armed forces) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Frank S Mason</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arteriosclerotic</u> DUE TO <u>cardio-vascular renal disease</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>54 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-18-58</u> , 19 <u>58</u> , to <u>1-19-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-19-58</u> , 19 <u>58</u> , and that death occurred at <u>4:00 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Cohen</u>		ADDRESS (Street, city or town, state) <u>Snow Hill, md</u>	
PHYSICIAN'S NAME (Type) <u>Paul Cohen</u>		DATE SIGNED <u>1-21-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 23/58</u>		22b. DATE THEREOF <u>Jan 23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>Snodgrass, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Way E. Dunning</u>		24a. REC'D BY REGISTRAR <u>Jan 24 '58</u>	
ADDRESS <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Dunning</u>	

1958 04 24

RECEIVED

1360

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City	c. LENGTH OF STAY IN 1b 18 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Pocomoke City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN S. McALLISTER		4. DATE OF DEATH January 4 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1873
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Joseph McAllister		14. MOTHER'S MAIDEN NAME Julia Briddell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Nellie M. McAllister, Pocomoke, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO VASCULAR DISEASE DUE TO (c) ATHEROSCLEROTIC VASCULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 10 YEARS 10 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pocomoke Worcester Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC. 1 1955 to JAN 4 1958 , that I last saw the deceased alive on JAN 4 1958 , and that death occurred at 3:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 212 MARKET ST. Pocomoke City, Md. DATE SIGNED 1-6-58			
ACTUAL SIGNATURE C. S. Hamilton M.D.		DATE SIGNED 1-6-58	
PHYSICIAN'S NAME (Type) C. S. HAMILTON		ADDRESS Pocomoke City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-7-58	22c. NAME OF CEMETERY Bethany Methodist	22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Watson		24a. REC'D BY REGISTRAR DATE JAN 9 58	24b. REGISTRAR'S SIGNATURE Quinn

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

MAN 9 1958

RECEIVED

1361

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pocomoke City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #3				d. STREET ADDRESS RFD #3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HATTIE G. CUTTEN				4. DATE OF DEATH Month January Day 15 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1867		9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen D. Redden				14. MOTHER'S MAIDEN NAME Mary Ellen Pilchard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Mellon Trader, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) Degenerative Heart Disease						INTERVAL BETWEEN ONSET AND DEATH Minutes Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1949 , to Jan. 15, 1958 , that I last saw the deceased alive on Jan. 10, 1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 302 Market St., Pocomoke City, Md. DATE SIGNED 1-16-58							
ACTUAL SIGNATURE Charles W. Trader M.D.				1-16-58			
PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.				302 Market St., Pocomoke City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-58		22c. NAME OF CEMETERY OR CREMATORY Cutten Family Cemetery Rural Pocomoke, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke, Md.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 20 1938

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 01354

1362

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>OCEAN CITY</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MANNIE HESTER PARSONS</u>				4. DATE OF DEATH Month Day Year <u>JAN. 5 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1876</u>		9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES EDWARD DAVIS</u>				14. MOTHER'S MAIDEN NAME <u>MARIALA PURNELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS HALLIE COSTUPOLOS OCEAN CITY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5th</u>		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5 Jan. 1958</u> to <u>5 Jan. 1958</u> , that I last saw the deceased alive on <u>5 Jan. 1958</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ocean City, MD</u> DATE SIGNED <u>9 Jan 58</u>							
ACTUAL SIGNATURE <u>N. P. Thomas</u> M.D.				PHYSICIAN'S NAME (Type) <u>N. P. THOMAS</u> <u>OCEAN CITY, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/9/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Barbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

15N 13C INT!

RECEIVED

1363

CERTIFICATE OF DEATH

01355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Marcus</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u> c. LENGTH OF STAY IN 1b <u>11 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Marcus</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Shelbert H. Ramsay Jr.</u> First Middle Last		4. DATE OF DEATH <u>Jan. 1 1958</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22 1896</u> yrs. Months Days Hours Min.
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Repairman</u>	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Shelby Ramsay</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Nickman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>506-03-6039</u>	
17. INFORMANT <u>Shelbert H. Ramsay Jr.</u> Address <u>Snow Hill, md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19, to <u>1/1/58</u> , 19, that I last saw the deceased alive on <u>12/30/57</u> , 19, and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Snow Hill Md</u> DATE SIGNED <u>1/2/58</u>			
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D.		PHYSICIAN'S NAME (Type) <u>DR. PAUL COHEN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 4 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christiansburg</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>May B. Morris</u> ADDRESS <u>Snow Hill, md</u>		24a. REC'D BY REGISTRAR <u>U. H. Hedrick</u> 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. 5

JAN 9 1958

RECEIVED

1364

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 BAKER ST</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE TOWNSEND RICHARDSON</u>				4. DATE OF DEATH Month Day Year <u>JAN 15 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 2, 1859</u>		9. AGE (In years last birthday) yrs. <u>98</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. P. OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>SNOW HILL MD (RFD)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN RICHARDSON</u>				14. MOTHER'S MAIDEN NAME <u>MARIA HOLLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MRS RALPH BRITTINGHAM BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interioschrotic C-V renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>15 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>15 Jan</u> , 19 <u>58</u> , and that death occurred at <u>10:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. S. Thomas</u>				DATE SIGNED <u>17 Jan 58</u>			
PHYSICIAN'S NAME (Type) <u>W. S. Thomas</u>				ADDRESS (Street, city or town, state) <u>Ocean City, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BOWEN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEWARK MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Budge Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAMES M. SMITH		MALE		45		JAN 15 1888		BALTIMORE, MD.		CLOCK REPAIRER	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		OCCUPATION		DATE OF DEATH	
MARRIED		JAN 15 1910		BALTIMORE, MD.		MARY E. SMITH		HOUSEWIFE		JAN 20 1933	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN	
HEART DISEASE		NATURAL		BALTIMORE, MD.		JAN 20 1933		10:00 AM		J. M. SMITH	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF SPOUSE		OCCUPATION		DATE OF DEATH	
J. M. SMITH		JAN 20 1933		BALTIMORE, MD.		MARY E. SMITH		HOUSEWIFE		JAN 20 1933	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF SPOUSE		OCCUPATION		DATE OF DEATH	
J. M. SMITH		JAN 20 1933		BALTIMORE, MD.		MARY E. SMITH		HOUSEWIFE		JAN 20 1933	

BUREAU V. S.

JAN 20 1933

RECEIVED

1365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>89 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROYDIE</u> Middle <u>M. T.</u> Last <u>RIDINGS</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 8, 1868</u> 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES MAC GREGOR</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH POWELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>MRS. WALTER MURPHY</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Head, Paranasal</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitosis Taxis &</u> DUE TO (c) <u>Anemia & Cachexia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>6 mo</u> <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis, Vascular Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>4 Jan</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>4 Jan</u> , 19 <u>58</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herman A. Robbins, M.D.</u>		ADDRESS (Street, city or town, state) <u>Berlin, Md</u>	
PHYSICIAN'S NAME (Type) <u>Herbert A. Robbins, M.D.</u>		DATE SIGNED <u>1/6/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Gubage</u>		ADDRESS <u>Berlin Md.</u>	
24a. REC'D BY REGISTRAR <u>W. E. Leach</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Leach</u>	
DATE <u>JAN 8 58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. S.

8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1366

CERTIFICATE OF DEATH

01358

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Milbourne Landing Road				d. STREET ADDRESS Rt # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GAYLORD Keith ROBERTSON				4. DATE OF DEATH Month January Day 3 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1919	
9. AGE (In years lost birthday) 38 yrs.		IF UNDER 1 YEAR Months 3 Days 19 Hours 58 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md. Dep. Forrests		10b. KIND OF BUSINESS OR INDUSTRY Ass't Dist. Forester	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Roy Robertson				14. MOTHER'S MAIDEN NAME Mae Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.II		17. INFORMANT Mrs. Lola Robertson, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DUE TO UNKNOWN (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH 30 MIN.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) POCOMOKE CITY WORCESTER MD.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 3, 1958 to JAN 3, 1958 , that I last saw the deceased alive on JAN 3, 1958 , and that death occurred at 723 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. Stanford Hamilton M.D.				ADDRESS (Street, city or town, state) 212 MARKET ST. 1-3-58			
PHYSICIAN'S NAME (Type) C. STANFORD HAMILTON				DATE SIGNED POCOMOKE CITY MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/58		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Storm Lake, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.				24a. REC'D BY REGISTRAR JAN 7 58		24b. REGISTRAR'S SIGNATURE W. F. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman H. Baker

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 7 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Spencer</u> Middle <u>Spencer</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 - 1898</u> yrs.
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Jenny Beckett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-206925</u>	
17. INFORMANT <u>Malinda Fillett (Sister)</u> Address <u>Snow Hill Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>526x</u> DUE TO <u>Brochiectasis</u> <u>Probably</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C. Bronchitis</u> DUE TO <u>Respiratory cold - Ankyriosis - being treated for years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 to 4 years</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatigue from a hunting trip around the farm</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>N.E. Sartorius, Sr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>N.E. Sartorius</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. USUAL CREMATION, 22b. DATE THEREOF <u>Jan 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deaughters Family</u>	
22d. LOCATION (City, town, or county) <u>Deaughters Family</u>		(State) <u>md</u>	
24. REC'D BY REGISTRAR <u>W. T. ...</u>		24b. REGISTRAR'S SIGNATURE <u>W. T. ...</u>	
24a. DATE <u>JAN 13 '58</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or reinterment.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AN 13 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01360

1347

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Md.</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pocomoke Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>R.F.D. 13</u>			
3. NAME OF DECEASED (Type or print) <u>First Jessie Middle Spratley Last</u>				4. DATE OF DEATH <u>Jan. 23</u> Month <u>19 58</u> Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>March 2, 1899</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Surry Co. Va.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Walter Spratley</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Price</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>War 1</u>			
16. SOCIAL SECURITY NO. <u>231 12 3561</u>		17. INFORMANT <u>John Strand</u> Address <u>Accomac, Va.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Arteriosclerotic attack</u> DUE TO (b) <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>N.E. Sartorius</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Jan. 24, 1958</u>			
EXAMINER'S NAME (Type) <u>N.E. Sartorius, Sr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>R.B. Wharton Memorial</u>			
22d. LOCATION (City, town, or county) <u>Parksley, Va.</u>		(State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u>			
ADDRESS <u>Accomac, Va.</u>		24a. RECORDING REGISTRAR <u>Jan 24 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Deane</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 1

1958. 08. 11

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1368 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, Film G225 2-13-58 et

Reg. Dist. No. 01361

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berlin</u> c. LENGTH OF STAY IN 1b <u>5 yrs +</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1 R 293 Germania</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> d. STREET ADDRESS <u>1 R 293 Germania</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Andrew George Washington</u> First Middle Last				4. DATE OF DEATH <u>Jan 28 1958</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15 1880</u> Year Month Day	
9. AGE (In years last birthday) <u>78</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Whitey helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>(?)</u>		17. INFORMANT <u>Rachael Newton - sister neighbors</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X (Probably) Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>minutes before</u> DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lived in untenable down quarters, on day quarters on dirt floor + sewer</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury seen</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>N. E. Sartorius Sr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>N. E. Sartorius</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1/29/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE				DATE <u>FEB 3 '58</u>		24c. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND - BUREAU OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
EDUCATION		MARITAL STATUS		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL		PHYSICAL		LABORATORY	
PATHOLOGICAL		TOXICOLOGICAL		BACTERIOLOGICAL		VIROLOGICAL		OTHER	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		HOURS	

BUREAU V. 3

EB 3 1958

RECEIVED

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CERTIFICATE OF DEATH

01362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hancock</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If instituting: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hancock</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City, Md</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> d. STREET ADDRESS <u>7 Baltimore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Lloyd Thomas Williams</u> First Middle Last		4. DATE OF DEATH Month <u>1</u> - Day <u>25</u> - Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Oswald Williams</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Horasky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-164986</u>	
17. INFIRMANT <u>Mrs. H. J. Williams</u> Address <u>Ocean City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebrovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 25, 1953</u> to <u>Jan 25, 1958</u> , that I last saw the deceased alive on <u>Jan 25, 1958</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. R. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>Ocean City, Md</u> DATE SIGNED <u>25 Jan 58</u>	
PHYSICIAN'S NAME (Type) <u>W. J. Thomas</u>		ADDRESS <u>Ocean City, Md</u> DATE SIGNED <u>25 Jan 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>B. T. George</u>	22d. LOCATION (City, town, or county) (State) <u>Georgetown, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Williams</u> ADDRESS <u>Ocean City, Md</u>		24a. RECEIVED BY REGISTRAR <u>25 Jan 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. Thomas</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

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BUREAU V. E.

JAN 27 1958

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